HEALTH RECORD

Massachusetts Department of Mental Retardation

(1) **Entry Date:** _____
(2) Entered By: _____

(To be completed or updated at the ISP and brought to all new medical contacts)

(3) Name _____ **(4) Likes to be called** _____

(5) D.O.B. _____**(6) Gender**_____ **(7) Soc. Sec #**_____ **(8) Religious Consideration:** _____

(9) Street Address 1 _____

(10) Street Address 2 _____

(11) City_____**(12) State**____**(13) ZIP**_____

(14) Tel. # _____

Health Insurance (type & numbers)

(15) Primary Name: _____ **(16)** Number: _____

(17) Secondary Name: _____ **(18)** Number _____

(19) Agency Responsible for Providing Care? ☐**No** ☐**Yes (20)** _____ **(21)** _____ **(22) Tel. #** _____
(If Yes, Name of agency) (Primary contact person)

(23) Consent Status:
☐ Can give own consent
☐ **Unable to give own consent**
☐ No Guardian
☐ Unknown
☐ Consent from guardian
(24) Name _____ **(25)** Tel. # _____

(26) Resuscitation Status:
☐ DNR
☐ Full Resuscitation
☐ Unknown
(27) If DNR, is comfort care form available? ☐ Yes ☐ **No** ☐ Unknown

(28) Health Care Proxy ☐ **No** ☐ Yes ☐ Unknown **(29)** Name _____ **(30)** Tel. # _____

Emergency Contacts

(31) Type: Emergency ☐ **Pharmacy** ☐

(32) Name _____

(33) Address Line 1: _____

(34) Address Line 2: _____

(35) City: _____**(36) State:** _____ **(37) Zip** _____

(38) Tel. _____

Repeat 31 -38 for other contacts using a separate sheet

Medications: (39) Medication Name: _____
(40) Reason for Prescription: _____
Dictionary #1
(41) If "other" explain: _____
(42) Frequency: _____
(43) Date Started: _____ **(44)** Date Stopped: _____
Repeat 39-44 on separate sheet for other medications

(45) Type of Allergy: (Select all that apply)
Medications ☐ Food ☐ Insects ☐ Environmental ☐
Other ☐ Unknown ☐ None ☐
(46) To what: _____
(47) Type of Reaction: _____

(48) Neurologic Medical Problem/Diagnosis (select all that apply)
Cerebral Palsy ☐ Epilepsy/Seizure Disorder ☐
Alzheimers Disease ☐ Other ☐ **(49)** _____

(50) Cardiovascular Medical Problem/Diagnosis (select all that apply) Coronary Artery Disease ☐ Congestive Heart Failure ☐
Hypertension ☐ Other ☐ **(51)** _____

(52) Respiratory Medical Problem/Diagnosis (select all that apply) Pneumonia ☐ Asthma ☐ COPD ☐ Recurrent Infection ☐
Aspiration ☐ Other ☐ **(53)**_ _____

(54) Gastrointestinal Medical Problem/Diagnosis (select all that apply) GERD ☐ Dysphasia ☐ Constipation ☐ Other ☐ **(55)**_ _

(56) Musculoskeletal Medical Problem/Diagnosis (select all that apply) Arthritis ☐ Osteoporosis ☐ Other ☐ **(57)** _ _____

(58) Kidney/Urinary Medical Problem/Diagnosis (select all that apply) Renal Insufficiency/Failure ☐ Urinary Retention ☐
Recurrent Infection ☐ Other ☐ **(59)** _ _____

(60) Cancer/Neoplasm Medical Problem/Diagnosis (select all that apply) Lung Cancer ☐ Prostate Cancer ☐ Stomach Cancer ☐
Colon Cancer ☐ Esophageal Cancer ☐ Pancreatic Cancer ☐ Liver Cancer ☐ Blood Cancer ☐ Breast Cancer ☐
Brain Cancer ☐ Other ☐ **(61)** _____

(62) Metabolic/Endocrine Medical Problem/Diagnosis (select all that apply) Diabetes ☐ Hyperlipidemia ☐ Hyperthyroidism ☐
Hypothyroidism ☐ Other **(63)** _ _____

(64) Syndromes Medical Problems/Diagnosis (select all that apply) Angelman Syndrome ☐ Autistic Disorder ☐ Cornelia DeLange
Syndrome ☐ Down's Syndrome ☐ Fetal Alcohol Syndrome ☐ Fragile X ☐ PKU ☐ Prader-Willi ☐ Rett Syndrome
Smith-Magenis Syndrome ☐ Tuberous Sclerosis ☐ Turner's Syndrome ☐ Velocardiofacial Syndrome (DiGeorge Syndrome) ☐
Williams Syndrome ☐ Other ☐ **(64A)** _ _____

(65) General Medical Problem/Diagnosis not previously identified**:** _____

Individual Name:_____

(66) Psychiatric Medical Problem/Diagnosis (select all that apply) Anxiety Disorder – General Anxiety ☐ Anxiety Disorder – OCD ☐ Anxiety Disorder – Panic Disorder/Agoraphobia ☐ Anxiety Disorder – PTSD ☐ Dementia Related Disorders ☐ Impulse Control Disorder ☐ Mental Disorder due to medical problem – related to Seizure Disorder ☐ Mental Disorder due to medical problem – related to medication side effects ☐ Mood Disorder – Bipolar Disorder ☐ Mood Disorder – Depressive Disorder ☐ Personality Disorder – Antisocial ☐ Personality Disorder – Borderline ☐ Personality Disorder – Paranoid ☐ Schizophrenia and thought disorders ☐ Psychotic Disorder not otherwise specified ☐ Sexual Disorder ☐ Substance Abuse Disorder ☐ Other ☐ **(67)** _____

(68)Communication:
- ☐ Able to Communicate
- ☐ Communication Difficulties/Uses Verbalizations
- ☐ Communication Difficulties/Uses Gestures
- ☐ Not Able to Communicate Needs
- ☐ Unable to Use Call Bell
- ☐ Only speaks/understands foreign language
- ☐ Unknown **(69)** _____

(70)Vision:
- ☐ Normal
- ☐ Low Vision
- ☐ Blind
- ☐ Wears Glasses
- ☐ Unknown

(71)Supportive Devices:
- ☐ Padded side rails
- ☐ Splints
- ☐ Braces
- ☐ Helmet
- ☐ Other (71A)_____
- ☐ Unknown

(72)Hearing:
- ☐ Normal
- ☐ Hard of Hearing
- ☐ Deaf
- ☐ Hearing Aid
- ☐ Unknown

(73)Toileting Ability:
- ☐ Continent
- ☐ Needs Assistance
- ☐ Incontinent
- ☐ Catheterized
- ☐ Unknown

(74)Medication Administration:
- ☐ Independent/Self Medicates
- ☐ Medication Administered by Staff
- ☐ Unknown

(75)Dining/Eating:
- ☐ Independent
- ☐ Needs Assistance
- ☐ Totally Dependent
- ☐ Fed Through a Tube
- ☐ Other (75A)_____
- ☐ Unknown

(76)Diet Texture:
- ☐ Regular
- ☐ Chopped
- ☐ Ground
- ☐ Puree
- ☐ Thickened Liquid
- ☐ Unknown

(77)Diet Type: _____

(78)Ambulation:
- ☐ Unknown
- ☐ Independent ☐ Steady ☐ Unsteady
- ☐ Needs Assistance ☐ 1 person ☐ 2+ people
- ☐ Ambulation Aids ☐Walker ☐W/C ☐Crutches

(78A)☐Owns own wheelchair

(78B) When was it acquired? _____

(79) Other ☐Yes ☐No ☐ Unknown

(81)Personal Hygiene:
- ☐ Independent
- ☐ Special Needs **(81A)**_____

(82)Oral Hygiene:
- ☐ Independent
- ☐ Special Needs **(82A)**_____

(83)Head of Bed Elevated:
- ☐ Yes
- ☐ No
- ☐ Unknown

(84) Any Previous Problems with Anesthesia? Yes ☐ No ☐ Unknown ☐

(85) If Yes, explain:_____

SPECIAL NEEDS

(86) Usual Response to Medical Exams: ☐ Cooperates ☐ Partially Cooperates ☐ Resistant ☐ Fearful ☐ Unknown

(87) Sedation for clinical visits ☐ No ☐ Yes ☐ Unknown **(88)** If Yes, Explain: _____

(89) If Yes, type of sedation used: _____

(90) Special positioning required for examination ☐ No ☐ Yes ☐ Unknown **(91)** If Yes, Explain:_____

(92) Double staffing required for assistance with exams ☐ No ☐ Yes ☐ Unknown **(93)** If Yes, Explain: _____

(94) Requires limited waiting periods for exams ☐ No ☐ Yes ☐ Unknown

(95) Appointment Schedule Preference: ☐ Early day appointments ☐ Prefers end of day appointments ☐ Unknown

(96) Special communication device/method ☐ No ☐ Yes ☐ Unknown **(97)** If Yes, (Explain): _____

(98) Pain Response: ☐ Normal ☐Unique ☐ Unknown **(99)** If Unique, Explain :_____

MEDICAL PROVIDERS

(100) Primary Care	**(103)Subspecialist/Type:** Dictionary #3
(100A)Name _____ (100F)Tel. #_____	(103A)Name _____ (103F)Tel. #_____
(100B)Address _____	(103B)Address _____
(100C)City (100D)State (100E) Zip	(103C)City (103D)State (103E)Zip
(101)Dental Care	**(104)Subspecialist/Type:** Dictionary #3
(101A)Name _____ (101F)Tel. #_____	(104A)Name _____ (104F)Tel. #_____
(101B)Address _____	(104B)Address _____
(101C)City (101D)State (101E)Zip	(104C)City (104D)State (104E)Zip
(102)Eye Care	**(105)Other Type:**
(102A)Name _____ (102F)Tel. #_____	(105A)Name _____ (105F)Tel. #_____
(102B)Address _____	(105B)Address _____
(102C)City (102D)State (102E)Zip	(105C)City (105D)State (105E)Zip
☐ **See attached for Additional Specialists**	

Individual Name: _____

(106) Living Status: ☐ Group Home ☐ Own Home ☐ Independent ☐ Home Sharing/Shared Home ☐ Other _____

(107) Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Domestic Partner ☐ Widow/Widower ☐ Other _____

(108) Work/Day Program Status: ☐ Community Day Support ☐ Day Habilitation ☐ Regular job ☐ Sheltered workshop ☐ Unknown

(109) Current Nursing Supports: ☐ In home <24 hr ☐ In home 24 hr ☐ Healthcare Coordination ☐ VNA may be accessible ☐ No Nursing supports ☐ At Day Program ☐ Unknown

IMMUNIZATIONS

110) TETANUS Status ☐ Unknown ☐ Allergic ☐ Never ☐ Administered **(111)**Date:_____

(112) FLU SHOT Status ☐ Unknown ☐ Allergic ☐ Never ☐ Administered **(113)**Date:_____

(114) PNEUMOVAX Status ☐ Unknown ☐ Allergic ☐ Never ☐ Administered **(115)**Date:_____

(116) HEPATITIS B VACCINE – Primary Series (3 Shots) Status
Primary Series (3 shots) ☐ Unknown ☐ Allergic ☐ Never ☐ Administered
(117) Date Shot #1 _____ **(118)** Date Shot #2 _____ **(119)** Date Shot #3 _____

(120) Hepatitis B Vaccine Booster Status ☐ Unknown ☐ Allergic ☐ Never ☐ Administered **(121)**Date:_____

(122) MEASLES/MUMPS/RUBELLA (MMR) Status ☐ Unknown ☐ Allergic ☐ Never ☐ Administered **(123)**Date:_____

(124) List any other vaccinations and dates (e.g., Lyme, Hepatitis A, Varicella, etc.)

_____

(125) Has the person ever had a positive skin test for tuberculosis? ☐ Yes ☐ No ☐ Unknown

(126) If yes, was any treatment given? ☐ Yes **(126A)**Describe _____ ☐ No **(126B)**Explain_____

(127) Is the last date of last PPD known? ☐ Yes **(127A)**Describe _____ ☐ No **(127B)**Explain_____

PAST MEDICAL HISTORY

(128) Medical History Contact Name: _____ **(129)** Relation _____

(130) Tel #_____ **(131)** Street Address _____ **(132)** City _____

(133) State: _____ **(134)** Zip:_____

(135) SURGERIES AND TRAUMA; HOSPITALIZATION; TYPE OF EVENT (select all that apply**)**:
☐ Broken Bones ☐Serious Trauma ☐ Other
☐ Hospitalization – Medical ☐ Hospitalization - Surgical ☐ Hospitalization - Psychiatric
(136) If Hospitalization, which hospital? _____ **(137)** Description _____
(138) Date of events in #135: _____

(139) Age menstruation started (women only): ☐ <8 ☐8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ >16 ☐ Unknown

(140) Still menstruating: ☐ Yes ☐ No (see #141) ☐ Unknown

(141) Age menstruation stopped: ☐ <50 ☐ 50 ☐ 51 ☐ 52 ☐ 53 ☐ 54 ☐ 55 ☐ 56 ☐ 57 ☐ 58 ☐ 59 ☐ 60 ☐ >60 ☐ Unknown

(142) Has individual ever given birth to a child? ☐ Yes ☐ No ☐ Unknown

(143) Gynecological exam status: ☐ Unknown ☐ Never conducted ☐ Administered **(144)** Date of last exam: _____

(145) PAP Smear Status: ☐ Unknown ☐ Never conducted ☐ Administered **(146)** Date of last exam: _____

(147) Any history of abnormal PAP smear? ☐ No ☐ Yes (describe) _____

(148) Mammogram Status: ☐ Unknown ☐ Never conducted ☐ Administered **(149)** Date of last exam: _____

(150) Neurologic Medical Problem/Diagnosis (select all that apply) Cerebral Palsy ☐ Epilepsy/Seizure Disorder ☐ Alzheimers Disease ☐ Other ☐ **(151)** _____

(152) Cardiovascular Medical Problem/Diagnosis (select all that apply) Coronary Artery Disease ☐ Congestive Heart Failure ☐ Hypertension ☐ Other ☐ **(153)** _____

INDIVIDUAL NAME: _____

(154) Respiratory Medical Problem/Diagnosis (select all that apply) Pneumonia ☐ Asthma ☐ COPD ☐ Recurrent Infection ☐ Aspiration ☐ Other ☐ **(155)**_ _____
(156) Gastrointestinal Medical Problem/Diagnosis (select all that apply) GERD ☐ Dysphasia ☐ Constipation ☐ Other ☐ **(157)**_ _
(158) Musculoskeletal Medical Problem/Diagnosis (select all that apply) Arthritis ☐ Osteoporosis ☐ Other ☐ **(159)** _ _____
(160) Kidney/Urinary Medical Problem/Diagnosis (select all that apply) Renal Insufficiency/Failure ☐ Urinary Retention ☐ Recurrent Infection ☐ Other ☐ **(161)** _ _____
(162) Cancer/Neoplasm Medical Problem/Diagnosis (select all that apply) Lung Cancer ☐ Prostate Cancer ☐ Stomach Cancer ☐ Colon Cancer ☐ Esophageal Cancer ☐ Pancreatic Cancer ☐ Liver Cancer ☐ Blood Cancer ☐ Breast Cancer ☐ Brain Cancer ☐ Other ☐ **(163)** _____
(164) Metabolic/Endocrine Medical Problem/Diagnosis (select all that apply) Diabetes ☐ Hyperlipidemia ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Other **(165)** _ _____
(166) Syndromes Medical Problems/Diagnosis (select all that apply) Angelman Syndrome ☐ Autistic Disorder ☐ Cornelia DeLange Syndrome ☐ Down's Syndrome ☐ Fetal Alcohol Syndrome ☐ Fragile X ☐ PKU ☐ Prader-Willi ☐ Rett Syndrome Smith-Magenis Syndrome ☐ Tuberous Sclerosis ☐ Turner's Syndrome ☐ Velocardiofacial Syndrome (DiGeorge Syndrome) ☐ Williams Syndrome ☐ Other ☐ **(167)** _ _____
(168) Psychiatric Medical Problem/Diagnosis (select all that apply) Anxiety Disorder – General Anxiety ☐ Anxiety Disorder – OCD ☐ Anxiety Disorder – Panic Disorder/Agoraphobia ☐ Anxiety Disorder – PTSD ☐ Dementia Related Disorders ☐ Impulse Control Disorder ☐ Mental Disorder due to medical problem – related to Seizure Disorder ☐ Mental Disorder due to medical problem – related to medication side effects ☐ Mood Disorder – Bipolar Disorder ☐ Mood Disorder – Depressive Disorder ☐ Personality Disorder – Antisocial ☐ Personality Disorder – Borderline ☐ Personality Disorder – Paranoid ☐ Schizophrenia and thought disorders ☐ Psychotic Disorder not otherwise specified ☐ Sexual Disorder ☐ Substance Abuse Disorder ☐ Other ☐ **(169)** _____

(170) General Medical Problem/Diagnosis not previously identified**:** _____

EVALUATION TYPE:

(171A)☐ AUDIOLOGICAL EXAM: **(171B)** Eval. Date Available? ☐ Yes **(171C)**Date: _____ **(171D)** ☐ No **(171E)** Why? _____

(172A)☐ EYE EXAM: **(172B)** Eval. Date Available? ☐ Yes **(172C)**Date: _____ **(172D)** ☐ No **(172E)** Why?_____

(173A)☐ DENTAL EXAM **(173B)** Eval. Date Available? ☐ Yes **(173C)**Date: _____ **(173D)** ☐ No **(173E)** Why? _____

(174A)☐ PHYSICAL EXAM **(174B)**Eval. Date Available? ☐ Yes **(174C)**Date: _____ **(174D)** ☐ No **(174E)** Why?_____

(175A)☐ BONE DENSITOMETRY **(175B)**Eval. Date Available? ☐ Yes **(175C)**Date: _____ **(175D)** ☐ No **(175E)** Why? _____

(176A)☐ SIGMOIDOSCOPY/COLONOSCOPY

(176B) Eval. Date Available? ☐ Yes **(176C)**Date: _____ **(176D)**☐ No **(176E)** Why? _____

(177A)☐ PROSTRATE SCREENING (PSA)

(177B) Eval. Date Available? ☐ Yes **(177C)**Date: _____ **(177D)**☐ No **(177E)** Why? _____

FAMILY HISTORY

(178) Relationship ☐ Biological Father ☐ Biological Mother ☐Brother ☐ Sister

(178A) Is Family Member Known? ☐No ☐Yes **(178B)** If Yes, is the family member deceased? ☐No ☐Yes ☐ Unknown

(178C) If Deceased, Age of Death _____ **(178D)** If Deceased, Cause of Death: _____ **(178E)** If Not Deceased, Date of Birth? _____

(179) Relationship ☐ Biological Father ☐ Biological Mother ☐Brother ☐ Sister

(179A) Is Family Member Known? ☐No ☐Yes **(179B)** If Yes, is the family member deceased? ☐No ☐Yes ☐ Unknown

(179C) If Deceased, Age of Death _____ **(179D)** If Deceased, Cause of Death: _____ **(179E)** If Not Deceased, Date of Birth? _____

(180) Relationship ☐ Biological Father ☐ Biological Mother ☐Brother ☐ Sister

(180A) Is Family Member Known? ☐No ☐Yes **(180B)** If Yes, is the family member deceased? ☐No ☐Yes ☐ Unknown

(180C) If Deceased, Age of Death _____ **(180D)** If Deceased, Cause of Death: _____ **(180E)** If Not Deceased, Date of Birth? _____

INDIVIDUAL NAME: _____

(181) Relationship ☐ Biological Father ☐ Biological Mother ☐Brother ☐ Sister

(181A) Is Family Member Known? ☐No ☐Yes **(181B)** If Yes, is the family member deceased? ☐No ☐Yes ☐ Unknown

(181C) If Deceased, Age of Death _____ **(181D)** If Deceased, Cause of Death: _____ **(181E)** If Not Deceased, Date of Birth? _____

Repeat above for additional family members, as necessary.

Is there any family history of:

(182) DIABETES ☐ Unknown ☐No ☐Yes **(183)** HIGH BLOOD PRESSURE ☐ Unknown ☐No ☐Yes

(184) HIGH CHOLESTEROL ☐ Unknown ☐No ☐Yes **(185)** HEART DISEASE ☐ Unknown ☐No ☐Yes

(186) OSTEOPOROSIS ☐ Unknown ☐No ☐Yes **(187)** COLON POLYPS ☐ Unknown ☐No ☐Yes

(188) CANCER ☐ Unknown ☐No ☐Yes **(189)** What Type?_____

(190) Are there any other diseases that "run in the family"? ☐ Unknown ☐No ☐Yes (give details)_____

(191) Has there been any genetic counseling in the family? ☐ Unknown ☐No ☐Yes, results: _____